CONTRACT DISCREPANCY REPORT

1. CONTRACT NUMBER
DROIGSA-06-00005

Report Number: CDRFY18-0004

Date: 12/11/2018

2. TO:
ICE
10 Burton Hills Blvd
Nashville, Tennessee
37215

3. FROM:
ICE
U.S. Immigration & Customs Enforcement
146 CCA Rd
Lumpkin, GA 31815

DATES

CONTRACTOR NOTIFICATION	CONTRACTOR RESPONSE BY: 1/11/2018	RETURNED BY CONTRACTOR	
12/11/2018			

4. DISCREPANCY OR PROBLEM *(Describe in Detail: Include reference in PWS / Directive: Attach continuation sheet if necessary.)*

See Attached Memo

5. SIGNATURE OF CONTRACTING OFFICER'S REPRESENTATIVE (COR)

ICE

6. TO: *(COR)*
ICE

7. FROM: *(Contractor)*

8. CONTRACTOR RESPONSE AS TO CAUSE, CORRECTIVE ACTION AND ACTIONS TO PREVENT RECURRENCE. ATTACH CONTINUATION SHEET IF NECESSARY. *(Cite applicable Q.A. program procedures or new A.W. procedures.)*

9. SIGNATURE OF CONTRACTOR REPRESENTATIVE SEE ATTACHED CONTRACTOR RESPONSE	10. DATE

11. GOVERNMENT EVALUATION OF CONTRACTOR RESPONSE/RESOLUTION PLAN: (*Acceptable response/plan, partial acceptance of response/plan, rejection: attach continuation sheet if necessary*)

12. GOVERNMENT ACTIONS (*Payment withholding, cure notice, show cause, other.*)

CLOSE OUT

	NAME AND TITLE	SIGNATURE	DATE
CONTRACTOR NOTIFIED			
COR			
CONTRACTING OFFICER			

Office of the Field Director
U.S. Department of Homeland Security
180 Ted Turner Drive SW
Atlanta, Georgia 30303

U.S. Immigration and Customs Enforcement

October 23, 2018

MEMORANDUM: CDR FY18-0004

FROM: **ICE**

PURPOSE:

This memorandum outlines the violations by CoreCivic in accordance with Performance-Based National Detention Standards (PBNDS), and the Inter-Government Service Agreement DROIGSA-06-00005. Immigration Customs Enforcement (ICE) will be making a twenty percent (20%) deduction per incident that led to the detainees' deaths, and failure to comply with CDR FY18-0003 corrective actions, for each month in which the incident occurred. CoreCivic is found to be in breach of contract performance based on the following:

1. The 2011 Performance-Based National Detention Standards Section (PBNDS 2011) 4.5, F. Suicide Prevention and Intervention states, "detainees in Special Management Unit (SMU) shall be personally observed and logged at least every 15 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly." PBNDS 2011 also states "All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring welfare checks at least every 8 hours conducted by clinical staff, and daily mental health treatment by a qualified clinician."

2. Per PBNDS 2011, Section 2.12 Special Management Units, (V) Expected Practices, B. Placement in Disciplinary Segregation, 2. Disciplinary Segregation Order, "A written order shall be completed and signed by the chair of the IDP (or disciplinary hearing officer) before a detainee is placed into disciplinary segregation. a. Prior to a detainee's actual placement in disciplinary segregation, the IDP chairman shall complete the disciplinary segregation order (Form I-883 or equivalent), detailing the reasons for placing a detainee in disciplinary segregation. All relevant documentation must be attached to the order. b. The completed

disciplinary segregation order shall be immediately provided to the detainee in a language or manner the detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operation of the facility. All written materials provided to detainees shall generally be translated into Spanish." The Quality Assurance Surveillance Plan (QASP) and the PBNDS 2011 minimum standards were incorporated in modification P00012, which direct the contractor on performance or give guidance to the contractor on contract performance. CoreCivic has been non-compliant under QASP Modification P00012 and the PBNDS 2011 minimum standards.

3. CDR FY18-0003: Addresses the failure of CoreCivic to properly make rounds while the detainee is in segregation and failure to conduct constant one-on-one observations. It also lists corrective actions that have not been followed by the CoreCivic staff.

FACTS

A thorough investigation was completed by ICE OPR External Reviews and Analysis Unit concerning the deaths of Personal Information and Personal Information Personal Information, which showed a number of violations. Outlined below are actions by CoreCivic's security staff/detention officers concerning the death of Personal Information and Personal Information. The investigation has revealed that disciplinary reports (packets) or SMU documentation – e.g., segregation orders and/or reviews were either not completed or completed incorrectly and not in accordance with the contract and CoreCivic policies. CoreCivic has failed to meet PBNDS standards 4.5 as outlined above and therefore CoreCivic's breach was a contributing factor in the death of Personal Information on May 17, 2017 and Personal Information on July 10, 2018. CoreCivic's negligence was a contributing factor in the death of both detainees at the Stewart Detention Center.

The security reviewer endorses overlapping concerns and recommendations cited in the Medical Conclusions section of ERAU's report related to failure to implement special needs orders for a low bunk/low tier, communications regarding Personal Information jump from the second tier, delay in calling 911, and officer failure to assist in performance of CPR. The following additional concerns expand on above-cited Safety and Security deficiencies and include observations not addressed in the ICE detention standards.

During two of three disciplinary incidents involving detainee Personal Information, no staff were present at the housing unit. The first was on April 13, 2017 when there was an apparent verbal altercation with another detainee, culminating in Personal Information being physically assaulted. The second was on April 27, 2017 when he jumped from the second tier to the first. In addition, in the hours preceding Personal Information suicide, the ICE left the post seven times, including for eight minutes after the detainee was last seen alive. Although SDC policy clearly states that officers are not to leave their posts until properly relieved, the randomness of these incidents and the fact that different officers were involved strongly suggest that leaving a post unsupervised is standard practice rather than coincidence. Whereas continual staff supervision is both fundamental and critical to assuring the safety of detainees and facility security, reviewers recommend that CoreCivic take steps to actively enforce facility policy.

In addition to leaving the unit unsupervised on seven occasions the night of Personal Information suicide, ICE made false entries to the Confinement Watch Log, also documented in an incident report. Specifically, he documented he made a round at 12:00 a.m., although video provides no evidence that he made a round and observed Personal Information at or around that time. He also documented a round at 12:28 a.m. when the video shows he was not in the housing unit. The gravity of false documentation stands on its own, but in this case, is heightened because the entries indicate Personal Information was observed alive at 12:00 a.m. and 12:28 a.m. when in fact, he was not observed at those times. Video evidence shows ICE made a round at Personal Information cell at 11:25:59 p.m. and his next round at 12:43:25 a.m. when he found the detainee hanging. The elapsed time between rounds was 77 minutes and 26 seconds.

Per policy, officer rounds are to be made every 30 minutes. Absent a system for electronically recording rounds, verifying officer compliance with policy necessitates random review of video footage rather than strict reliance on logs entries. Reviewers recommend that CoreCivic develop procedures for supervisory review of video at periodic intervals to verify officers conduct rounds in the required frequency. Frequent officer rounds in segregation units are another fundamental security practice supporting detainee safety and welfare.

Supervisors are required to make one round in the RHU per shift. Video evidence shows ICE reviewed documents at detainee Personal Information cell at 11:58 p.m. and 12:11 a.m. On neither occasion did he look directly into the cell. Reviewers recommend that CoreCivic enforce the requirement to look in each cell during rounds and per the above, develop procedures for supervisory review of video to verify rounds are properly conducted.

Video showing Personal Information involvement in an altercation with another detainee on April 13, 2017 was reviewed by the Unit Manager immediately following the incident. Despite the fact the video provided clear evidence that Personal Information was assaulted and did not fight back, he was charged with fighting and placed in segregation pending disciplinary hearing. During the five days Personal Information was segregated, the charge was reviewed by the investigating officer and UDC, and his placement on segregation was reviewed by the Security Chief. No action was taken to dismiss the charge and return Personal Information to general population, suggesting the process for reviewing the merit and validity of disciplinary charges was a perfunctory exercise, only.

A. Compliance Findings from Personal Information

- **Violations Cited** PBNDS 2011 Section 2.12, Special Management Units, Section (V)(M), states, "detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly."

  - The 2011 PBNDS Section 4.5 Section F, Suicide Prevention: "All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring...."

- **Custody Classification System, section (V)(H)(3)**, which states, "Staff shall complete a special reclassification within 24 hours before a detainee leaves the Special Management Unit (SMU)".

  - A special reclassification was not completed when the detainee was released from RHU on April 18, 2017.

- **Disciplinary System, section (V)(H)(3)**, which states, "The detainee in IDP proceedings shall have the right to: present statements and evidence, including witness testimony, on his/her behalf."

  - Detainee Personal Information requested a witness at his hearing for fighting. Hearing documentation does not reflect that a witness was called, or that the detainee rescinded the request.

  This also violates **SDC Policy 15-100 Detainee Discipline, section 15-100.4 (F)(5)** which mirrors the standard.

- **Disciplinary System, section (V)(H)(4)**, which states, "The IDP shall: conduct the hearing on the first business day after receiving the UDC referral, unless the detainee waives the 24-hour notification provision and requests an immediate hearing. In cases where a hearing is delayed, the reason(s) must be documented (e.g., a continuing investigation of facts, unavailability of one or more witnesses, etc.) and approved by the facility administrator."

  - The UDC referred the April 13, 2017 disciplinary incident for charge of fighting to the IDP on Friday, April 14, 2017. The IDP hearing was not held until Tuesday, April 18, 2017.

- **Special Management Units, section (V)(A)(1),** which states, "A supervisor shall conduct a review within 72 hours of the detainee's placement in administrative segregation to determine whether segregation is still warranted. The review shall include an interview with the detainee."

  - The 72-hour reviews conducted by ICE on April 16, 2017 and April 28, 2017 do not document that the detainee was interviewed.

- **Disciplinary System, section (V)(H)(2)(c)**, which states, "The detainee in IDP proceedings shall have the right to: "having an IDP hearing within 24 hours after the conclusion of the investigation."

  - The investigation for the Thursday, April 27, 2017 disciplinary incident involving Personal Information jump from the second tier was concluded on April 28, 2017, resulting in referral to the UDC or IDP. There was no UDC review, and the IDP hearing was not held until Tuesday, May 2, 2017.

  This delay also violates **SDC Policy 15-100 Detainee Discipline** which mirrors the standard.

- **Special Management Units, section (V)(B)(2)(b)**, which states, "The completed disciplinary segregation order shall be immediately provided to the detainee in a language or manner the

detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operation of the facility."

- There is no documentation the May 3 and May 5, 2017 IDP reports imposing disciplinary segregation sanctions were issued to detainee Personal Information The signature and date sections are blank on both forms.

- **Special Management Units, section (V)(L),** which states, "Detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule."

  - ICE logged security rounds at 11:22 p.m. on May 14, 2017 and at 12:00 a.m. and 12:28 a.m. on May 15, 2017. He is seen on video making a round at 11:26 p.m. on May 14, 2017 as logged; however, there is no video evidence that he conducted rounds at 12:00 a.m. and 12:28 a.m. on May 15, 2017.

This also violates **SDC Restricted Housing Unit Post Orders, section (III)(B)(1),** which states, "Detainees in SMU shall be personally observed and logged at least every thirty (30) minutes on an irregular schedule.

- **SDC Policy 9-16, Emergency Response Team (ERT), section 9-16.4 (E)(2), Responder 2-Camera Operator Duties,** "Respond to all non-medical emergencies and/or incidents with a video camera, one (1) extra camera battery, and one (1) extra recording media;" **and, SDC Housing Unit Post Orders, section (II)(C),** which states, "If assigned to the Emergency Response Team (ERT), ensure you are aware of your responsibilities and have access to any necessary equipment required for a response."

  - Officer [redacted], the ERT camera operator on the shift the suicide occurred, did not respond with the handheld camera because she forgot her assignment.

- **SDC Housing Unit Post Orders, Section (III)(A)(1, 2),** which state, "Maintain inmate/resident accountability by making frequent, irregular tours throughout the housing unit. Be observant and visible to the inmate/resident population; Monitor activities within the housing unit throughout your tour of duty"; **and, SDC Housing Unit Post Orders, Section (IV)(A),** which states, "Never leave your post for any reason unless properly relieved by an assigned officer or the Shift Supervisor/Unit Manager."
  - There were no staff in the housing unit on April 13, 2017 when Personal Information was assaulted by another detainee.
  - There were no staff in the housing unit on April 27, 2017 when Personal Information jumped from the upper tier.
  - ICE left his post on seven occasions between the hours of 10:00 p.m. on May 15, 2017 and 2:00 a.m. on May 16, 2017.

- **SDC Restricted Housing Unit Post Orders, Section (III)(B)(1)(ii)**, which states, "Observation will be documented on the 10-1F Confinement Watch Log or equivalent contractually required form."

  - ICE documented rounds at 12:00 a.m. and 12:28 a.m. on May 15, 2017. Video evidence shows he did not make these rounds.

- **SDC Restricted Housing Unit Post Orders, Section (III)(G)(2)(b)**, which states, "The inmate/resident will be escorted by a minimum of two (2) employees who must maintain physical control of the inmate/resident at all times."

  - On May 16, 2017, ICE escorted a detainee from Unit 7A to Unit 5 by himself.

- **SDC Restricted Housing Unit Post Orders, Section (III)(B)(1)(i)** which requires the observation of detainees during rounds to include, "looking in each cell to ensure that no unusual or unauthorized activities are occurring." Video evidence does not support that ICE ICE looked in Personal Information cell during his round at 11:58 a.m. on May 14, 2017 or when he returned to the cell 12 minutes later.

- **SDC Policy General Emergency Information, Section (III)(A)(3)**, which states, "Any employee who discovers an inmate/resident engaging in self-harm shall immediately: If the suicide attempt involves hanging by the neck, alert other staff to retrieve the cut down tool and make every effort to relieve the pressure off the victim's neck. Upon arrival of the cut down tool, cut down the victim."

  - ICE did not call for responding staff to bring the cut down tool; rather, he left the unit to retrieve one himself. As a result, there was a delay of approximately one minute in opening the cell door and relieving the pressure off Personal Information neck.

B. Findings from Personal Information

From August 14-16, 2018, the ICE OPR/ERAU conducted a review of the death of ICE detainee Personal Information who died on July 10, 2018, while in the custody of ICE at the SDC. At the conclusion of the onsite review, ERAU briefed preliminary findings to Atlanta Field Office and facility personnel. Significant preliminary findings are summarized below, and all findings will be discussed in the final Detainee Death Review report.

PBNDS 2011, Special Management Units, Section (V)(M), states, "detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly."

The officers assigned to Personal Information segregation unit during the second shift (2PM to 10PM) and third shift (10PM to 6AM) on the night of his death, failed to conduct rounds every 30

minutes, and allowed approximately 113 minutes to lapse between the last time Personal Information was seen alive by the second shift officer, and the time he was found hanging in his cell by the third shift officer.

Violations Cited: PBNDS 2011, Special Management Units, Section (V)(M), states, "detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule. For cases that warrant increased observation, the SMU personnel shall personally observe detainees accordingly."

Per PBNDS 2011, 2.12 Special Management Units, V. Expected Practices, B. Placement in Disciplinary Segregation, 2. Disciplinary Segregation Order, "A written order shall be completed and signed by the chair of the IDP (or disciplinary hearing officer) before a detainee is placed into disciplinary segregation. a. Prior to a detainee's actual placement in disciplinary segregation, the IDP chairman shall complete the disciplinary segregation order (Form I-883 or equivalent), detailing the reasons for placing a detainee in disciplinary segregation. All relevant documentation must be attached to the order. b. The completed disciplinary segregation order shall be immediately provided to the detainee in a language or manner the detainee can understand, unless delivery would jeopardize the safe, secure, or orderly operation of the facility. All written materials provided to detainees shall generally be translated into Spanish. Where practicable, provisions for written translation shall be made for other significant segments of the population with limited English proficiency."

PBNDS 2011, Section 4.5, Section F, Suicide Prevention and Intervention states, "detainees in SMU shall be personally observed and logged at least every 30 minutes on an irregular schedule." For cases that warrant increased observation, the Special Management Unit (SMU) personnel shall personally observe detainees accordingly; The 2011 Performance-Based National Detention Standards Section 4.5 Section F, Suicide Prevention: "All suicidal detainees placed in an isolated confinement setting will receive continuous one-to-one monitoring."

OUTCOME

The investigation for Personal Information revealed that disciplinary reports (packets), or SMU documentation – e.g., segregation orders and/or reviews were not done or completed incorrectly. failure to complete required documentation, failure to complete UDC review, and failure to conduct hearings properly egregious and not in accordance with the contract QASP and PBNDS Section 2.12, and your own policies. ICE also considers the above infractions of the security staff and supervisors for failure to conduct rounds every thirty minutes non-complaint with QASP and PBNDS Section 4.5.

The officers assigned to Personal Information segregation unit during the second shift (2PM to 10PM) and third shift (10PM to 6AM) on the night of his death, failed to conduct rounds every 30 minutes, and allowed approximately 113 minutes to lapse between the last time Personal Information was seen alive by the second shift officer, and the time he was found hanging in his cell by the third shift officer. Based on the findings ICE concluded that the death of Personal Information was gross negligence on behalf of CoreCivic. ICE considers the above infractions of the security staff and

supervisors for failure to conduct rounds every thirty minutes egregious and non-complaint with QASP and PBNDS Section 4.5.

In accordance with the QASP, ICE will withhold these deductions against the monthly invoices for unsatisfactory performance documented through surveillance of CoreCivic activities gained through the investigations as follows:

Personal Information – Deductions off the Bed Day Detention invoice for the month of May 2017 will be assessed.

- 20% for PBNDS Section 2.12
- 20% for Section 4.5

Personal Information – A 20% deduction for the Bed Day Detention invoice for the month of July 2017 will be assessed for PBNDS Section 2.12.